Health Care Organization/Association/ System Comments

Virginia Association of Nurse Practitioners

DaVita

Virginia Hospital and Healthcare Association

Virginia Oral Health Coalition

Virginia Community Healthcare Association

Pharmaceutical Research and Manufacturers of America

Date: August 24, 2011

To: Virginia Health Reform Initiative Advisory Council

RE: Comments on September 9 Memorandum on Preparing for Potential 2012 Health Benefit Exchange legislation.

From: Cynthia Fagan, RN, MS, FNP-BC
President , Virginia Council of Nurse Practitioners

The Virginia Council of Nurse Practitioners (VCNP), representing the professional interests of more than 6000 nurse practitioners in the state and the patients they serve, offers these comments on the Health Benefit Exchange (HBE). As discussions related to HBE and reimbursement move forward, the VCNP urges the committee to employ provisions that promote sustainable practice and access to care.

Nurse practitioners play a vital role in the provision of high quality, cost effective health care to Virginians and the majority of those nurse practitioners provide primary care services. One of the principle goals of VCNP is to educate others about the important role nurse practitioners play in the delivery of health care services in the Commonwealth of Virginia.

In order to maximize the services provided by nurse practitioners to the expanding numbers of citizens needing health care in Virginia, attention must be given to ensure adequate and equitable HBE models and reimbursement policies that reimburse nurse practitioners for the services they provide.

Access to care is impeded by the fee for service structure for provider reimbursement. The current structure limits access by paying according to the provider disciplines rather than for the services provided. This payment policy limits the ability to link providers with their care management outcomes and effective care coordination, increases costs associated with billing practices, delays care and creates a lack of transparency. As noted on page 11 of the third memorandum, the certification of qualified plans requires sufficient choice of providers and information on provider availability. VCNP requests that all VHRI deliberations regarding health care providers recognize the key role nurse practitioners already perform in the provision of care to low income, underserved communities. Nurse practitioners need to be specifically included as essential community providers in such networks and included generally as providers in all qualified health plans and basic health plan discussions. It is essential that language arising from the VHRI deliberations remain provider neutral.

Nurse practitioners have been the mainstay for providing Medicaid sponsored primary care in underserved communities, both urban and rural for years. Currently, nurse practitioners are

recognized as fee for service Medicaid providers in the Commonwealth. With the anticipated increase of those eligible for health care services, it is essential that insurance plans recognize nurse practitioners as providers for those enrolled in managed Medicaid plans. The principle of payment for services provided, regardless of which payer entity is providing them, should be extended for managed Medicaid beneficiaries.

As the HBE are being defined, it is imperative that nurse practitioners are included in the plan development and structure and as providers in the basic health plan. Nurse practitioners play an essential role in providing access to high quality, cost effective health care in the Commonwealth. Partnership with nurse practitioners in the governance or affiliate structures of the HBE will take advantage of their knowledge and expertise and help ensure effective utilization of this resource. Development of payment systems reflecting who is providing the care and the true costs of care will help assure transparency, cost effectiveness, accountability of the care provided, and efficient utilization of the healthcare workforce.

Thank you for the opportunity to comment on the important work of the VHRI.

Cynthia Fagan, RN, MS, FNP-BC
President, VCNP

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August 26, 2011

Cindi B. Jones
Director
Virginia Health Reform Initiative
Office of the Secretary of Health and Human Services
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

Re: Comments on September 9 Memorandum on Preparing for Potential 2012 Health Benefit Exchange Legislation.

Dear Director Jones:

DaVita appreciates the opportunity to provide comments to the September 9 Memorandum on Preparing for Potential 2012 Health Benefit Exchange Legislation. The DaVita patient population includes more than 123,000 patients who have been diagnosed with end stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning 43 States and the District of Columbia, the DaVita network includes more than 1,700 locations. DaVita's nationwide network is staffed by 35,000 teammates (employees). In Virginia, DaVita has the privilege of providing dialysis treatment for over 4,480 individuals with kidney failure throughout our 56 centers across the Commonwealth. This comprehensive care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

Your request for comments was particularly focused on (1) drawing lines of responsibilities between legislation, the Exchange Governing Board and the Exchange Executive Director and (2) whether Virginia should incorporate a "basic health plan" option as a type of "bridge" insurance product for families with incomes that hover but fluctuate near the income dividing line between being eligible for Medicaid and eligible for premium and cost-sharing subsidies inside the Exchange. We believe the Virginia Health Reform Initiative Advisory Council and Task Force Members also could benefit from the experience of dialysis providers and comments regarding how ESRD patients will be impacted by current proposed Federal regulations. These regulations likely will have significant implications for Virginia's ESRD patients and the State's Medicaid program.

As discussed in greater detail below, ESRD is a life-threatening condition that requires comprehensive coverage and care for those living with the disease. Accordingly, our comments are predicated on the fact that we expect CMS to ensure that any essential health benefits package for any health plan in the Exchanges includes coverage of ESRD-related services. To

this end, our letter focuses on the following four items: (1) clarifying that Medicare Secondary Payer (MSP) provisions apply to qualified health plans; (2) allowing individuals with ESRD to access Exchange-subsidized coverage; (3) requiring qualified health plans to offer a sufficient choice of providers for individuals with ESRD; and (4) prohibiting qualified health plan benefit designs with inadequate protections for individuals with ESRD. We provide these comments in light of the statutory provisions contained in the Affordable Care Act ("ACA") as well as recent Federal proposed implementing regulations. These proposed regulations include (1) a proposed regulation released by the Department of Health and Human Services (HHS) entitled "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans"[1] ("Exchange Establishment Regulation") and (2) a proposed regulation released by the Department of the Treasury entitled "Health Insurance Premium Tax Credit"[2] ("Exchange Subsidy Regulation").

Background

ESRD, or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys are functioning at 10%–15% of their normal capacity or below and, therefore, cannot sustain life. Kidneys are vital organs that remove toxins from the blood and perform other functions that support the body, such as balancing fluid and electrolytes, and producing certain hormones. When kidneys fail, they cannot effectively perform these functions, and renal replacement therapy, such as dialysis or a kidney transplant, is necessary to sustain life. Moreover, kidney failure affects all other organ systems in the body as well.

The most common type of dialysis is hemodialysis, which is predominantly performed in specialized outpatient facilities, as well as acute care settings, but it can also be performed at home. Other dialysis modalities include peritoneal dialysis, which is typically performed by the individual in their home, and nocturnal hemodialysis, which takes place either in-center or at home during the night. Due to the significant impact of ESRD on the body, the resulting fragility of those with the disease, and the amount of time involved in treatment, access to the renal replacement therapy modality that is right for the individual is of critical importance.

Hemodialysis is a therapy that filters waste products, removes extra fluid, and balances electrolytes (sodium, potassium, bicarbonate, chloride, calcium, magnesium and phosphate), replacing the mechanical functions of the kidney. Traditional in-center hemodialysis is generally performed at least three times a week for about four hours each session. **Pursuant to Section 226A of the Social Security Act (SSA), individuals who are medically determined to have ESRD, who are not otherwise entitled, may become entitled to Medicare Part A benefits, and eligible to enroll in Medicare Part B, the third month after the month in which a regular course of renal dialysis is initiated. Also of importance, MSP provisions of Section 1862(b)(1)(C) of the SSA provide, in relevant part, that a group health plan may not take into account that an individual is entitled to, or eligible for, benefits under Medicare during the 30-month period which begins with the first month in which the individual becomes entitled to ESRD benefits under Medicare.**

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[1] 76 Fed. Reg. 41866 (July 15, 2011).
[2] 76 Fed. Reg. 50931 (August 17, 2011).

1. Clarify that MSP Provisions Apply to Qualified Health Plans

In its response to the "Request for Comments" released by the Office of Consumer Information and Insurance Oversight (OCIIO),[3] DaVita raised important considerations relating to the applicability of Medicare Secondary Payer (MSP) rules to qualified health plans (inside and outside of an Exchange). In the Request for Comments and subsequent meetings, DaVita urged CMS to clarify and confirm the applicability of MSP policy to qualified health plans due to considerations relating to (1) policy, (2) legality and (3) Federal cost-savings.

- *Policy.* By providing that ESRD patients may access their private group health plan as primary coverage for 30 months before Medicare assumes this responsibility, MSP has ensured the continued viability of the successful 40-year public-private partnership to care for individuals with ESRD. MSP coverage is critical as those with ESRD often have multiple co-morbidities and rely on private coverage for assistance with out-of-pocket costs and to maximize choice of providers. The intent of the ACA was to maximize and protect consumer choice; failure to apply MSP consistently would effectively eliminate consumer choice for patients suffering from kidney failure.

- *Legality.* Qualified health plans offered by qualified employers in a small and large group market in an Exchange are "group health plans."[4] Section 1862(b)(1)(C) of the SSA describes the MSP policy for ESRD for "group health plans" as defined in Section 1862(b)(1)(A)(V) as having "the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to Section 5000(d) of such Code." It is clear from the statutory definitions that a "qualified health plan," as that term is used in the ACA, is a subset of a "group health plan" as that term is used in IRC § 5000(b)(1).[5] Thus, all statutory provisions that governed IRC § 5000(b)(1) group health plans pre-ACA must be assumed to continue to apply to those plans.[6]

- *Federal Cost-Savings.* Industry estimates have found that ensuring current MSP law applies to group health plans would save the Federal Government $1.3 billion over 10 years.

Unfortunately, in the Exchange Establishment Regulation, CMS proposes to set forth a new regulation at 45 CFR 155.430(b)(2)(ii) to require that an Exchange must permit a QHP issuer to terminate coverage if an enrollee becomes covered in other minimum essential coverage (including Medicare Part A). DaVita believes this proposed regulation runs counter to, and could undermine, current MSP policy. In addition to the significant negative impact such a policy could have on Virginia ESRD patients, the proposed regulation could have a negative impact on Virginia's Medicaid budget. Many ESRD patients become dually eligible for both Medicare and Medicaid due to the high costs of coinsurance and other out-of-pocket expenses associated with their care. If patients cannot access their private plans that often have

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[3] 75 Fed. Reg. 45584 (Aug. 3, 2010).
[4] ACA 1312 § (f)(2); ACA § 1304(a)(3)
[5] ACA § 1301
[6] The courts "assume that Congress is aware of existing law when it passes legislation." South Dakota v. Yankton Sioux Tribe, 522 U.S. 329, 352 (1998).

significantly lower coinsurance than the 20% not covered by Medicare, these patients will spend down their assets sooner and enter the Medicaid program prematurely. This will shift costs from private plans to Medicaid in an environment where Medicaid eligibility is already set to expand to 138% of the FPL further straining state budgets. Furthermore, if any of these patients happen to be the primary insured for a family, the entire family coverage could be adversely affected causing their spouses and children to seek state assistance from Medicaid, SCHIP and other state funded coverage options. **As such, DaVita requests that the Virginia Health Reform Initiative Advisory Council and Task Force Members urge CMS to clarify the regulation at 45 CFR 155.430(b)(2)(ii) and confirm the applicability of MSP policy to qualified health plans.**

2. Allow Individuals with ESRD to Access Exchange-subsidized Coverage

In its response to the "Request for Comments" released by the Office of Consumer Information and Insurance Oversight (OCIIO), DaVita also raised important considerations relating to the ability of individuals with subsidized Exchange coverage to maintain such coverage and not be forced from such plans simply because they develop ESRD. In the Request for Comments and subsequent meetings, DaVita urged CMS to ensure that such individuals have the right to choose between subsidized Exchange coverage and Medicare coverage due to considerations relating to (1) policy, (2) legality and (3) Federal cost-savings.

- *Policy.* The ACA provides new premium credits and cost-sharing subsidies for the purchase of individual coverage in an Exchange, but disallows such assistance for individuals eligible for "minimum essential coverage," including Medicare Part A.[7] Allowing individuals to choose subsidized Exchange coverage is critical because otherwise individuals with ESRD would be forced to leave an Exchange simply because of their ESRD diagnosis. Moreover, it appears likely that, over time, a growing percentage of Exchange members who are able to purchase affordable coverage through an Exchange as a result of ACA subsidies will be disenfranchised from such coverage once they develop ESRD. Further compounding the problem, dependents and spouses of these individuals could lose their coverage altogether, given the fact that Medicare is not offered as a family or dependent benefit.[8]

  DaVita also notes that employer penalties under ACA for failing to offer acceptable health insurance are based on the acceptance of subsidies through the Exchange. Consequently, it appears there is effectively no penalty for employers with at least 50 FTEs that do not offer coverage to these most vulnerable individuals. Those with ESRD would simply move to Medicare and, if eligible, Medicaid without the benefit of Exchange-subsidized private coverage. DaVita believes this policy is antithetical to the spirit of ACA, which otherwise intends to allow individuals to maintain their current coverage.

  Allowing individuals with ESRD to choose between subsidized Exchange coverage and Medicare is also important from a clinical perspective. Because those with ESRD often

[7] IRC § 36B(c)(2)(B)(i); IRC § 5000A(f)(1)(A)(i)
[8] This concern also relates to the MSP policy discussion.

have multiple co-morbidities, they often rely on their private or group coverage for services not covered by Medicare and to assist with payment for the Medicare beneficiary out-of-pocket obligations. Good prescription drug coverage also is imperative for individuals with ESRD as they typically have as many as eight to ten prescription medications and private or group coverage tends to offer better coverage with fewer restrictions and lower co-payment obligations than Medicare.[9]

- *Legality.* Regulatory and case law have confirmed that simply being eligible for enrollment does not constitute being eligible for coverage. Under Section 226A of the Social Security Act, an individual with ESRD is entitled to Medicare Part A and eligible to enroll in Part B if they have "filed an application for benefits." Thus, in order to be "eligible for coverage," one must file an application.

- *Federal Cost-Savings.* Industry estimates have found that disallowing individuals from being removed from subsidized Exchange coverage simply because they develop ESRD would save the Federal Government $3.7 billion over 10 years.

Unfortunately, in the Exchange Subsidy Regulation, CMS proposes to set forth new regulations at 26 CFR 1.36B-2(c)(2)(iii) and 26 CFR 1.36B-2(c)(2)(v) which appear to disallow an individual with ESRD from choosing to not apply for Medicare benefits under Section 226A of the Social Security Act and, thereby, retain their subsidized Exchange coverage. In addition to the significant negative impact such a policy could have on Virginia ESRD patients, the proposed regulation could have a negative impact on Virginia's Medicaid budget. As with the previous discussion on MSP-applicability, Virginia Medicaid would experience cost increases due to an increased number of dually-eligible patients who will now qualify for Medicare and Medicaid. These patients will spend down their assets faster due to greater co-insurance responsibility resulting from their loss of private coverage. **As such, DaVita requests that the Virginia Health Reform Initiative Advisory Council and Task Force Members urge CMS to clarify the regulations at 26 CFR 1.36B-2(c)(2) to provide that those individuals with Exchange-subsidized coverage who subsequently develop ESRD, but do not file an application for Medicare benefits, will remain eligible for Exchange-subsidized coverage.**

3. Require Qualified Health Plans to Offer a Sufficient Choice of Providers for Individuals with ESRD

In the Exchange Establishment Regulation, CMS proposes to set forth a new regulation at 45 CFR 155.1050 as follows:

- *An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.*

This regulatory language hews very close to the statutory language contained in Section 1311(c)(1)(B) of the ACA and CMS itself acknowledges this broad standard affords State

[9] These concerns also relate to the MSP policy discussion.

Exchanges significant flexibility to set State-specific standards.[10] **DaVita urges Virginia to set a standard of 30 minutes average drive time from home to delivery site as an appropriate general minimum standard for chronically ill patients, such as those with ESRD.**[11]

DaVita notes that the NAIC raised such network adequacy concerns in its July 11, 2011 "Adverse Selection White Paper." The NAIC noted:

- *[D]ifferences in the breadth of qualified health plan provider networks could also occur within an Exchange, with less healthy individuals likely to gravitate to broader network products. If certain health plans exclude certain specialists or include very high levels of cost-sharing, this could drive selection against more comprehensive plans.*

Earlier NAIC deliberations on this issue specifically highlighted concerns that some carriers would deter patients with high use or high cost conditions from enrolling in their plans by removing specialists (e.g. renal specialists, oncologists) from their network or imposing unaffordable levels of cost sharing on routine treatments needed for high cost conditions (e.g. 90% cost sharing on dialysis to deter ESRD patients).[12]

Guaranteeing network adequacy is a particularly important issue for individuals with ESRD as an individual's life depends on the ability to access dialysis treatment at least three times each week. As such, DaVita urges that Virginia's Exchanges establish a general minimum standard for qualified health plan networks (inside or outside of an Exchange) of 30 minutes average drive time from home to delivery site for chronically ill patients, such as those with ESRD. For example, Virginia could establish a minimum standard of 30 minutes average drive time for chronically ill patients living in metropolitan areas and reasonable drive time standards, as determined by Virginia, for chronically ill patients living in non-metropolitan areas.

4. Prohibit Qualified Health Plan Benefit Designs with Inadequate Protections for Individuals With ESRD or Who Develop ESRD

In the Exchange Establishment Regulation, CMS seeks comment on a potential additional requirement that the Exchange establish specific standards under which QHP issuers would be required to maintain, among other things, "a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner."[13] DaVita believes this is an important benefit design concern related to a health plan's use of an inadequate in-network choice of providers to discourage the enrollment of individuals with significant health needs. Health plans that limit access to in-network dialysis for ESRD patients may also limit coverage of out-of-network care

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[10] 76 Fed. Reg. 41893

[11] DaVita notes, for example, that other States (e.g. New Jersey) have network adequacy regulations which provide that certain "specialized services" (including licensed renal dialysis) must be available "within 20 miles or 30 minutes average driving time, whichever is less" for 90 percent of covered persons within each county or service area.

[12] The BCBSM letter to the NAIC was downloaded at this link on 8/24/2011

[13] 76 Fed. Reg. 41894

through such means as higher out-of-network cost-sharing, which shifts a greater share of liability to covered persons.

DaVita notes this very concern is raised in the NAIC's Managed Care Plan Network Adequacy Model Act. According to the Model Act:

- *In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.*

DaVita urges Virginia to adopt this NAIC standard as a minimum regulatory requirement for all qualified health plans (inside or outside of an Exchange).

DaVita appreciates this opportunity to offer our comments, concerns, and suggestions to the Virginia Health Reform Initiative. We would be pleased to provide any additional information or clarification relating to the comments contained herein. Please do not hesitate to contact me should you have any questions relating to this comment letter.

Sincerely,

Jeremy Van Haselen
Public Policy Director
DaVita

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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August 26, 2011

The Honorable William A. Hazel, Jr., M.D.
Secretary of Health & Human Resources
Commonwealth of Virginia
1111E. Broad Street, Suite 4001
Richmond, VA 23219-1922

Dear Secretary Hazel:

On behalf of Virginia's hospitals and health systems, thank you for the opportunity to comment on the third background memorandum issued by the Virginia Health Reform Initiative.

While the latest memorandum focuses on obtaining input regarding the role of the Bureau of Insurance and the Health Benefit Exchange (HBE)-related responsibilities of the General Assembly, the governing board and its executive director, we would like to return briefly to a topic that we addressed in our letter dated June 29, 2011.

General Principles
In that letter we outlined some general principles that we believe the Health Reform Advisory Council should apply as it develops its recommendations for the structure and operation of the HBE. We recommend that these performance benchmarks be applied by the General Assembly when establishing and chartering the HBE governing body. Suggested performance areas include:

- *Providing effective choice of plans for its customers;*
- *Achieving high levels of satisfaction from individuals and small business customers of the HBE with the plan comparison and selection tools, web-site, enrollment and other administrative systems made available through the Exchange;*
- *Demonstrating rapid enrollment growth among previously uninsured individuals or small groups; and*
- *Maintaining a stable risk profile relative to individuals and small groups who opt for coverage outside of the exchange.*

Based on further discussion regarding the desired outcomes, we would like to suggest that consideration be given to weighting health plan benchmark measures so that an aggregate score also could be calculated. This would combine the benefits of transparency for the individual performance measures set by the Exchange with the ability to compare and differentiate plans using a more comprehensive measure of overall value. Weightings should be developed by the HBE Board so that the aggregate score provides a basis for evaluating which plans are best able to meet the needs of the individual consumer and small businesses.

Two additional principles that we believe merit consideration which were not included in our earlier letter are:

- *If a plan meets all of the criteria set by the Exchange, it should be allowed to participate.*
- *If a health plan doesn't qualify one year, there should be no prohibition from being considered for inclusion the next year; i.e. there should be no waiting period to participate, subject to any limitations necessitated by open enrollment periods that may be established by the Exchange.*

Role of Bureau of Insurance

In our June 29 letter we also addressed the question of the role of the Bureau of Insurance (BOI), expressing a preference for Alternative 3, which focuses the Bureau on its current roles but assigns new plan certification criteria to the HBE Board. In light of the additional information provided in the chart on pages 11 and 12 of VHRI's memorandum, we would like to add a clarifying comment. Regarding the certification of qualified plans, it appears there are various activities (e.g. provide adequate networks) that may currently be the responsibility of other state agencies (e.g., VDH) or which are being largely fulfilled currently via national accreditation systems (e.g., NCQA). We recommend that all PPACA responsibilities not assigned to the BOI should be the responsibility of the HBE, with the expectation that they would not duplicate existing regulatory systems or effective accreditation programs (e.g., by deeming plan NCQA accreditation with meeting certain plan performance requirements).

Health Benefit Exchange Responsibilities

As VHRI's memorandum notes, the General Assembly will be responsible for creating the Exchange, establishing its governance structure and defining the parameters of the governing board's discretion. We support assigning all of the other responsibilities listed on pages 14 and 15 of the memorandum to the governing body of the HBE, subject to these qualifications and exceptions:

- On page 15, item 3.h refers to certain goals for the Exchange. We believe it is appropriate for the Board to set such goals, but we are assuming that the ones noted in the memorandum were meant to be illustrative only. If they were meant to be explicit, we believe that setting such definitive goals at this point is premature, and that such goal setting should be reserved for the Board.
- We recommend eliminating any role for the Exchange regarding health plans outside the exchange. For example, on page 15, item 3.i refers to defining congruence of competition policy inside and outside HBE, and on page 16, item 7 refers to market rules inside and outside the HBE. As the role of the HBE is further defined, any reference to involvement with plans outside the Exchange should be eliminated.
- Only the General Assembly has the ability to amend oversight and regulatory authority for the BOI, so we recommend elimination of items 3.i.ii.4 and 3.i.iii.4 on page 15.

Regarding the oversight committees noted on page 15 in item 3.h.ii.1, we recommend that the HBE Board be required to submit to the Governor and the General Assembly an annual report that includes a certified audit.

The decision making authority delegated to the Executive Director of the Exchange on page 17 of the memorandum is appropriate.

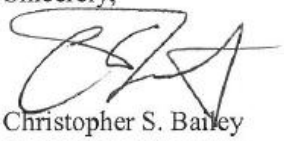
Basic Health Plan

An additional question posed in the memorandum is whether Virginia should incorporate a "basic health plan" in the HBE as a way to provide a "bridge" insurance product for families

with incomes that fluctuate near the income threshold for determining whether they are eligible for Medicaid or premium and cost-sharing subsidies. This is a complex issue that requires further analysis and would be an appropriate matter for the Board to decide following a thorough review that includes input from all of the affected parties. One particular concern we have regarding the introduction of a "basic health plan" is the risk to access to care and safety net providers if such plans were authorized to apply deeply inadequate Medicaid provider payment rates to a broader population.

Thank you for the opportunity to comment on how Virginia's Health Benefit Exchange should be structured. We would be happy to provide whatever additional feedback would be helpful as you develop the recommendations to be presented to the Governor and General Assembly by October 1.

Sincerely,



Christopher S. Bailey
Senior Vice President

Virginia Oral Health Coalition
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To: Virginia Health Reform Initiative

From: Tegwyn Brickhouse, DDS, PhD; Chair, Virginia Oral Health Coalition
Sarah Bedard Holland; Executive Director, Virginia Oral Health Coalition

Re: Comments on "Preparing for Potential 2012 Health Benefits Exchange Legislation"

The Virginia Oral Health Coalition appreciates the opportunity to provide comment to the Advisory Council of the Virginia Health Reform Initiative as it relates to the Third Background Memorandum on Health Benefit Exchange Issues--Topic: Preparing for Potential 2012 Health Benefit Exchange Legislation.

The Coalition is aware that many important decisions await direction from the Federal Government, including an outline of the benefit package offered as part of the Exchange. To that end, the Coalition would like to reiterate its strong belief that the **pediatric dental benefit within the Exchange must be Affordable, Accessible and Understandable.**

- It is imperative that the Exchange includes a pediatric-only dental benefit. As you are aware, §1302(a) of the Affordable Care Act requires that the essential benefits package include a pediatric oral health benefit. As such, subsidies and cost sharing are available for a child to access the pediatric oral health. Cost sharing and subsidies are not available for adult benefits offered within family plans. As a result, if a family plan is the only plan available, parents may choose to forgo the dental benefit entirely as it may become too expensive. The Coalition is not opposed to having affordable family plans in the Exchange, our belief is that all Virginians should have access to dental insurance. We simply feel that a child-only dental benefit must be available through plans within the Exchange to make the allocation of premium assistance clearer and allow consumers the most access to the mandated pediatric dental benefit.

- Qualified dental plans must demonstrate a network of dental providers that is adequate in volume, expertise and distribution. Once a pediatric-only dental benefit has been included in the Exchange, it will be equally important to ensure a sufficient number of providers to meet the demand of children in the Exchange, including children with special health care needs.

- Parents and caregivers must be aware of the pediatric dental benefit and the purchase options must be understandable, given the complexities of enrolling and obtaining dental care with potentially parallel medical and dental benefits.

The Coalition stands ready to assist the Commonwealth as a resource on this important matter and we look forward to being involved in the process when the substance of the Exchanges is discussed at the Virginia Health Reform Initiative.

Virginia Oral Health Coalition

Funded by a Generous Grant from the DentaQuest Foundation:

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The Virginia Dental Association

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Rappahannock Area Health District
Virginia Department of Health
Virginia Department of Medical Assistance Services

August 22, 2011

To: Virginia Health Reform Initiative

From: Rick Shinn, Director of Government Affairs
Virginia Community Healthcare Association

Re: Comments on Exchange White Paper #3 - Preparing for Potential 2012 Health Exchange Benefit Legislation

Summary on Issues Specific to Community Health Centers:

For health plans that desire to participate in the exchange, we ask that, per the relevant federal health reform law and language:

- Consideration be given to protecting the inclusion of any and all Federally Qualified Health Centers as essential community providers, where available, or where they may become available in the future, that serve predominantly low-income, medically underserved individuals.

- Per the relevant federal law under Public Law 111-148, payments to Federally Qualified Health Centers should be protected as described under the law.

ISSUES SPECIFIC TO COMMUNITY HEALTH CENTERS (ALSO KNOWN AS FEDERALLY QUALIFIED HEALTH CENTERS)

As the Health Benefits Exchange develops, and relevant legislation is formulated. we ask that certain critical issues relevant to Community Health Centers be kept in mind.

For health plans that desire to participate in the exchange, we ask that, per the relevant federal health reform law and language:

1) Consideration be given to protecting the inclusion of any and all Federally Qualified Health Centers as essential community providers, where available, or where they may become available in the future, that serve predominantly low-income, medically underserved individuals.

   This will help ensure that health plans offered through the exchange will provide sufficient access and choice of providers in all geographic areas of the Commonwealth.

   One way to help attain this would be that health plans be required to include any and all

Federally Qualified Health Centers willing to participate with the health plan.

To exclude this protection will put at risk thousands of Virginians who may not be able to access healthcare services due to geographic and transportation issues. One suggested legislative solution would be to include in relevant health benefits exchange legislation the following example:

a. The Health Benefit Exchange shall require that each health plan, as a condition of participation in such Exchange, shall (1) offer to each essential community provider that is a covered entity listed in Section 340B (a)(4)(A) of the Public Health Service Act and that provides services in the geographic area served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all of the ambulatory services covered by the plan that the provider offers to provide and (2) reimburse each such entity for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act.

2) Per the relevant federal law under Public Law 111-148, payments to Federally Qualified Health Centers should be protected as described under the law:

a. If any item or service covered by a qualified health plan is provided by a Federally Qualified Health Center (as defined in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U>S.C. 1396a(bb)) for such item or service.

CONCLUSION

We thank you for the opportunity to offer comments on the issues on the development of for Virginia's Health benefit Exchange. We look forward to future opportunities to comment as this process moves forward.

Sincerely,

Rick

Richard D. Shinn
Director of Public Affairs
Virginia Community Healthcare Association

cc: R. Neal Graham, CEO, Virginia Community Healthcare Association

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Kristin Parde
Senior Director
State Policy

PhRMA

August 25, 2011

The Honorable William A. Hazel
Secretary of Health and Human Resources
Patrick Henry Building
1111 East Broad Street
Richmond, Virginia 23219

By Electronic Mail

Re: Comments on September 9 Memorandum on Preparing for Potential 2012 Health Benefits Exchange Legislation

Dear Secretary Hazel:

The Pharmaceutical Research and Manufacturers of America (PhRMA) is pleased to respond to the Virginia Reform Initiative's request for comments related to the Virginia Health Benefit Exchange ("HBE"). PhRMA is a voluntary, non-profit organization representing the nation's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives.

Well-structured HBEs offering choice and competition among health plan options can help small businesses and individuals obtain improved coverage. We appreciate the state's solicitation of comments from interested parties with respect to the model legislation. We also look forward to participating in the ongoing discussions related to the structure of the HBE. At this juncture, PhRMA would like to submit comments on several key elements that we believe must be included in a state HBE model.

Maximizing choice of qualified private plans within new state-level Exchanges

We recommend that states promote a broad choice of qualified private insurance plans for eligible small businesses, families, and individuals. That is, a state Exchange should facilitate the availability of health insurance plans that meet federal certification requirements of health plans as qualified health plans and not otherwise seek to exclude plans or limit consumer choices within these new marketplaces. The Administration and Congressional architects of The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152), jointly referred to as the Affordable Care Act (ACA), have

advocated for increasing plan choices for individuals and families.[1] We agree. This is also consistent with the design of one of the most successful HBE-type models – the Federal Employees Health Benefit Program (FEHBP) – which provides high-quality, comprehensive health insurance coverage to over 9 million federal employees, retirees, and dependents while providing a wide array of private plan options (including national and local plans). Policymakers have long pointed to FEHBP as a model for making high-quality, affordable coverage available to individuals and small businesses.

Providing a broad choice of qualified plans will help small businesses and individuals who typically lack such choices in today's marketplace. Providing this choice and, therefore, an opportunity, to select a plan that best meets its purchaser's needs is one of the key benefits of HBEs. Additionally, broad choice of plans will minimize the likelihood of disruption as some workers' coverage switches from employer groups to HBEs. With choice among the set of plans prepared to meet the ACA's consumer protection and quality standards, it is more likely that employees will maintain rather than lose access to the plans and provider networks with which they are satisfied.

HBEs that do not offer the full set of qualified plans would limit consumer choice and could significantly diminish the benefits of competition over time. If a qualified plan is not offered in an HBE in a given year, it may be very difficult for it to sustain a viable presence in the market. Therefore, it may not be available to compete in future years, leaving consumers with fewer choices and those plans that were included in HBEs facing less competition.

The ACA includes important eligibility requirements that health plans must meet to qualify for participating in the new state-based HBEs. Qualified health plans must provide the "essential health benefits package," limit cost-sharing to specified levels, meet actuarial value standards within the HBE, offer at least one qualified plan in the "silver" and "gold" level within the HBE, and charge the same premium rate inside and outside the HBE (§1301(a)(1)). Moreover, health insurance issuers must be licensed and in good standing and comply with the ACA's new insurance reforms and consumer protections, such as requiring guaranteed availability of coverage, prohibiting discriminatory premium rates (e.g. modified community rating), barring pre-existing condition exclusions, and requiring comprehensive benefits.

Health plans must also meet specific criteria to qualify for participation in an HBE. ACA requires the U.S. Secretary of Health and Human Services (Secretary) to develop these certification criteria, which include marketing requirements, provider adequacy requirements

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[1] Remarks by the President to a Joint Session of Congress on Health Care; the White House: Office of the Press Secretary; September 9, 2009. "The Senate is Ready to Act on Health Care: Our Reform Plan Will Protect the Market for Innovation." Senator Max Baucus (D-MT); Wall Street Journal Op-Ed; October 15, 2009.

(including essential community providers), quality improvement strategy requirements, and accreditation requirements for consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.

Enhance and Build upon the Private Insurer Delivery Model

An HBE is intended to be a market mechanism for making qualified insurance plans available for purchase by consumers. An HBE should allow health plans that meet certification requirements to provide coverage and services in the way they believe can provide the best care. Because plans will be accountable for organizing and delivering care effectively (including meeting new standards for quality and patient protections), HBEs should preserve the availability of plans to organize and contract with providers to deliver medical care and not seek to "carve out" items and services. Carving out services from plans would defeat the point of assuring that plans are accountable for meeting these new standards and assuring high-quality care since they would be unable to manage some services that affect their results on other aspects of care.

Facilitate Transparency and Fairness to Consumers

A HBE should be administered in a way that is responsive to consumer concerns in order to ensure that quality health care is available in plans offered to state residents. An HBE should create a process for patients and stakeholders to provide input into the decision-making process, ideally in a public forum. Specifically, state open meetings laws should apply to the meetings of the HBE Board.

The HBE offers an opportunity for consumers to select a plan best suited to their individual needs. This cannot be done without access to clear and concise information about benefits, cost-sharing and co-payments, formularies, and appeals processes. Patients should also have access to data on prevention and wellness programs, medication management programs, and programs for addressing chronic conditions. The HBE website is the primary venue for patients seeking coverage through the HBE and should provide user-friendly and clear access to this information to empower patients to choose the plan best suited for their individual needs.

Structure and Governance

The governance structure of the HBE will play a significant role in the level of competition that is promoted in the HBE. PhRMA believes that the HBE should be housed in an independent public entity (akin to the Security and HBE Commission) to ensure a mode of recourse for participants. It is essential that the HBE not be housed in agencies where either regulatory or purchasing conflicts of interest may exist.

In order to safeguard the integrity of the HBE, it is important that in addition to patient and stakeholder input, the legislature and executive branch maintain a degree of oversight. The Board of the HBE should report annually to the Governor, Commissioner, and appropriate members of the legislature on the operations of the HBE, including financial integrity, fee assessments, health plan participation and ratings, enrollee participation and satisfaction, and any other relative items. In addition, an advisory committee should be created comprised of stakeholders appointed by the HBE Board and approved by the Governor. Committee members should represent a diverse range of expertise and perspectives including consumers, health plan administrators, advocates for enrolling minority and hard to reach populations, and health care providers and pharmaceutical and medical device manufacturers. The Advisory committee should be available to the Board for consultation on proposed policies, procedures, regulations, fees and other matters regarding the development, implementation, and on-going operations of the HBE.

We believe that the Virginia HBE creates an opportunity for secure quality healthcare for the state's uninsured. We appreciate your consideration of our comments. Please feel free to contact us with any questions.

Sincerely,

Kristin Parde